Doug Jameson, Psy.D.
CA license #PSY19189
510-301-2712

Informed Consent to Treatment

I give my consent to Doug Jameson, Psy.D. (hereafter Dr. Jameson) to provide me with psychological services. These services may consist of several interviews, treatment sessions, the review of various documents and records from my background, and interviews with other individuals who are familiar with me (with the client's written consent).

Risks and Benefits Statement

Taking part in psychotherapy may result in numerous benefits, including, but not limited to, decreased stress and anxiety, fewer negative thoughts and/or self-sabotaging behaviors, improved relationships, increased comfort in social and professional situations, and increased self-confidence. These benefits may require substantial effort and willingness on my part to change my feelings, thoughts and behaviors.

Dr. Jameson makes no guarantees that psychotherapy will yield any or all of the benefits outlined above. Participating in therapy may also involve emotional discomfort, including remembering and discussing painful or unpleasant events, feelings and experiences. This process may evoke strong feelings of sadness, anger, fear, and other unpleasant emotions. There may be times when Dr. Jameson challenges my perceptions and assumptions of myself and others and offers different perspectives. The issues I present may result in unintended outcomes, including changes in my personal relationships.

During this process I may find myself feeling worse before I feel better. This is generally a typical aspect of psychotherapy. Personal growth and change may be easy and swift at times, but may also be slow and frustrating at other times. I agree to discuss any concerns that I might have with Dr. Jameson throughout the course of treatment.

Confidentiality Statement

I understand that all of the information which I share with Dr. Jameson is confidential with the following exceptions:

a. If a client expresses or a client's family member reports to Dr. Jameson a serious threat to harm someone, Dr. Jameson must warn the person and notify the police.
b. If a client tells Dr. Jameson that they intend to harm themselves, then Dr. Jameson may call 911 or insist upon going to an emergency room.
c. If Dr. Jameson suspects child abuse, then he must make a report to the appropriate authorities.
d. If Dr. Jameson suspects abuse of an elderly or dependent adult, Dr. Jameson must make a report to the appropriate authorities.

I understand that in the case of a delinquent account, a collection agency may be employed to seek payment however information released to them will consist solely of session dates and account balances.

I understand that Dr. Jameson is not available 24 hours a day and in the event of a life-threatening emergency, I must call 911 or go to an emergency room for immediate assistance.

I understand that if I choose to use e-mail to communicate with Dr. Jameson that he can not guarantee the confidentiality of those messages.

Financial Responsibility and Fee Agreement

I agree to pay $120 due at each appointment.

I fully intend to pay any and all charges incurred for services and there is a reasonable probability that I will be able to meet the financial obligations noted herein.

Should my account be referred for collection, I agree to pay all fees and expenses incurred. I agree to pay an additional 30% of the referred amount to cover the collection costs.

There will be an additional charge on any personal checks that are returned by the bank.

Late Cancellation/No Show Policy

Because appointments are carefully scheduled and your time is reserved for you, office policy requires that you give Dr. Jameson 24-hour notice when canceling an appointment. I understand that should I fail to do so, then I will be charged a late cancellation/no show fee of $120. There are no exceptions to this policy.

Dr. Jameson will wait 15 minutes past a client's appointment time. I understand that being more than 20-minutes late may mean that I forfeit the session and am charged the full fee.

I will notify Dr. Jameson of any changes in address or phone number.

Acknowledgement

I have read this carefully and agree to all terms and conditions within it. I hereby freely give my consent to be treated by Dr. Jameson.

______________________________		______________________________	
Client Signature	Date	Doug Jameson, Psy.D.	Date

Client's Name: ___________________________________ Date of Birth:_______________

Address:____

City:__________________________ State:_________ Zip:_______________________

SSN:___________________________ Home Phone: ______________________________

Cell phone:________________________

Emergency contact name and phone number:_______________________________________

Medication Allergies:________________________________

Current Medications: ____